



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MOTOR VEHICLES
Medical Review Office
Washington, DC 20001



DIABETIC MEDICAL QUESTIONNAIRE

(THE FOLLOWING QUESTIONS MUST BE COMPLETED BY A LICENSED PHYSICIAN)

NAME OF APPLICANT: _____
LAST NAME FIRST NAME MIDDLE NAME

ADDRESS: _____

DC DRIVER'S LICENSE NUMBER: _____ EXPIRATION DATE: _____

AGE AT ONSET OF DIABETES: _____ SEX: _____

1. Statements regarding physical and mental impairments:

2. Has patient ever experienced a ☐ diabetic coma, ☐ insulin coma or ☐ hypocupremic reaction?

How often has this occurred and when was the last coma or reaction?

3. Does patient take insulin or oral hypoglycemic agents or a combination of both? ☐ Yes ☐ No. Describe the type of medication taken and dosage: _____

4. What diet does the patient follow: CHO _____ P _____ F _____ Calories _____

5. Do you consider this person physically qualified to operate a motor vehicle safely? ☐ Yes or ☐ No.

If not, please explain:

6. Do you feel that any special conditions should be imposed in connection with the issuance or renewal of a driver's license to this person for a five-year period? If yes, please explain:

PHYSICIAN'S SIGNATURE

DATE OF THIS REPORT

ADDRESS

(AREA CODE) TELEPHONE NUMBER

PERMISSION TO RELEASE THIS INFORMATION

I hereby authorize my physician to release the above information to the Government of the District of Columbia's Department of Motor Vehicles. However, this material is confidential and cannot be released to other agencies, public or private, without my express written permission.

Signature of Applicant: _____ Date: _____

For additional information, call 202-727-5000, or visit www.dmv.dc.gov